

**DIABETES MANAGEMENT CARE PLAN / REVIEW**

DDDGP  GSED  OTHER

Patient's Name: ..... Date of Birth:.././.....Height (for BMI)..... GP:.....

INITIAL & EVERY 3 MONTHS								* 6 - 12 MONTHS	* ONCE PER YEAR			Referral information Include dates seen by Service Provider
Date	Wgt (Kg)	BP	Date Hb A1c	Hb A1c	Home BSLs Control	Current Therapy	Altered dose or therapy	Foot Exam (Refer to Note 2)	LIPIDS	RETINAL EXAMINATION (Refer to Note 3)	MICROALBUMIN SCREENING Serum Creatinine	<u>Ophthalmologist/Optometrst</u> Name: Tel: Dates seen: <u>Podiatrist</u> Name: Tel: Dates seen: <u>Endocrinologist</u> Name: Tel: Dates seen: <u>Pharmacist</u> Name: Tel: Dates seen: <u>Diabetes Nurse Educator/Dietitian</u> Name: Tel: Dates seen: Other (please specify) ..... ..... ..... Medications: (handwrite or print off computer record and attach)
Initial					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Date: .././.....  Pulses: <u>  N  D  A  </u> Sensation: <u>  N  D  A  </u>	Date ...../...../.....  Chol: HDL:  Trig:	Date ...../...../.....  Normal <input type="checkbox"/>  (R) - Retina - (L) <input type="checkbox"/> - N - <input type="checkbox"/>	Date ...../...../.....  Specimen Type: Timed <input type="checkbox"/> Spot <input type="checkbox"/>	
3 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Foot Deformity? Y / N Nail Deformity? Y / N Active Y / N Foot Lesion ? Y / N	LDL:  Lipid Lwr Therapy?  Y / N	<input type="checkbox"/> -DNPR- <input type="checkbox"/>  <input type="checkbox"/> - PDR - <input type="checkbox"/>	Result: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>  Creatinine:	
*6 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Date: .././.....  Pulses: <u>  N  D  A  </u> Sensation: <u>  N  D  A  </u>		<input type="checkbox"/> - N/V - <input type="checkbox"/>  Other eg Glauc./Cataract		
9 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Foot Deformity? Y / N Nail Deformity? Y / N Active Y / N Foot Lesion ? Y / N				
*12 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Date: .././.....  Pulses: <u>  N  D  A  </u> Sensation: <u>  N  D  A  </u>	Date ...../...../.....  Chol: HDL:  Trig:	Date ...../...../.....  Normal <input type="checkbox"/>  (R) - Retina - (L) <input type="checkbox"/> - N - <input type="checkbox"/>	Date ...../...../.....  Specimen Type: Timed <input type="checkbox"/> Spot <input type="checkbox"/>	
15 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Foot Deformity? Y / N Nail Deformity? Y / N Active Y / N Foot Lesion ? Y / N	LDL:  Lipid Lwr Therapy?  Y / N	<input type="checkbox"/> -DNPR- <input type="checkbox"/>  <input type="checkbox"/> - PDR - <input type="checkbox"/>	Result: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
18 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Date: .././.....  Pulses: <u>  N  D  A  </u> Sensation: <u>  N  D  A  </u>				

21 months					Satisfactory Borderline Unsatisfactor y Unknown	Diet only OHA Insulin Insulin/OHA	OHA Insulin Insulin/OHA	Foot Deformity? Y / N Nail Deformity? Y / N Active Foot Lesion ? Y / N	Y / N	<input type="checkbox"/> - N/V - <input type="checkbox"/> Other eg Glauc./Cataract	Creatinine:
<b>Notes:</b> 1. Diet only/OHA/Insulin/Insulin and OHA with current; If change of dose or therapy circle 2 <sup>nd</sup> column. 2. For pulses & sensation indicate either: N = Normal D = Decreased A = Absent N = Normal DNPR = Diabetic Non Prolific Ret PDR = Prolific Diabetic Ret N/V = Not visualised											

**A combined program of the Dandenong District and Greater South Eastern Divisions of General Practice**